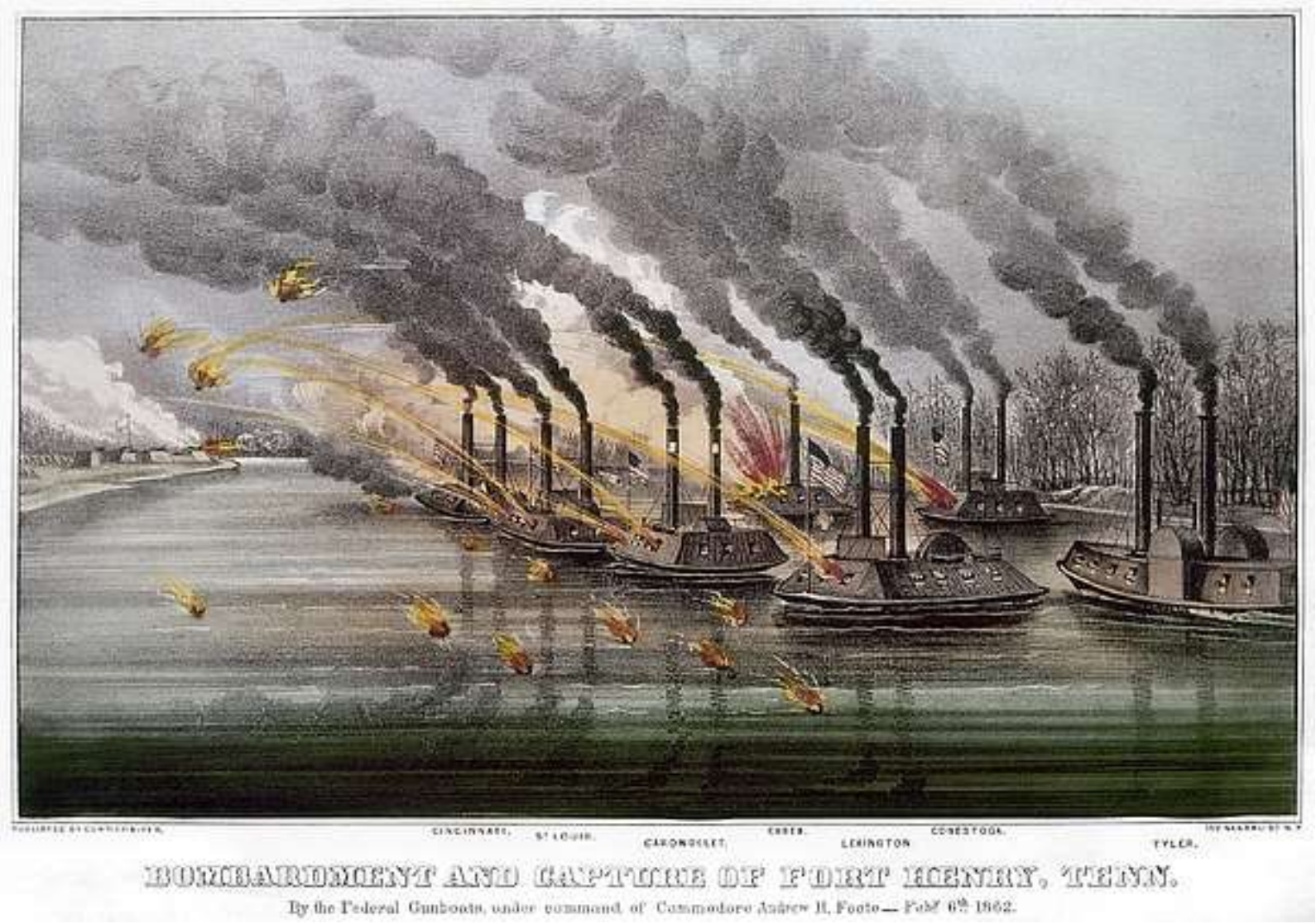
THE NORTHERN HOSPITAL

ACUTE BEHAVIOURAL EMERGENCIES - PHYSICAL RESTRAINT



Union Ironclad attack on Fort Henry, 6th February 1862, contemporary lithograph print, Currier and Ives, New York.

February 15th

In consideration of the circumstances governing the present situation of affairs at this station, I propose to the commanding officer of the Federal Forces, the appointment of commissioners to agree upon the terms of capitulation of the forces and fort under my command, and in that view suggest an armistice until 12.00 o'clock today,

Very respectfully, your obedient servant,
Gen. Simon Bolivar Buckner

H^d Qrs. Army in the Field
Camp near Donelson, Feby 16th

Gen. S.B Buckner
Confed. Army,

Sir: Yours of this date proposing Armistice, and appointment of Commissioners, to settle terms of Capitulation is just received. No terms except an unconditional and immediate surrender can be accepted.
I propose to move immediately upon your works.

I am Sir: very respectfully
Your obt. sevt.
U.S Grant
Brig. Gen.

After the Confederate defeat at Fort Donelson, the female academy and Stewart college at nearby Clarksville, Tennessee, were converted to hospitals.

"Sunday the news came. Such panic-stricken people were never before seen. The wounded were being brought up. The citizens were running. There were already two hospitals here which were filled with the sick, and they, poor fellas, were crawling out from every place, walking, going on horseback, in wagons".
Nannie Haskins.

The Union army was right behind the wounded. they met no resistance. a white flag flew above tiny fort defiance west of town, and mayor smith came out to inform the union commander that the confederate army had retreated to Nashville.

Farmer John Barker wrote in his diary that there were nothing but "Lincolnites" throughout the county.

An uneasy Federal occupation of Clarksville began.

Early in the war, a union squad closed in on a single ragged Confederate, and he obviously didn't own any slaves. He couldn't have much interest in the constitution or anything else. They said, "What are you fighting for anyhow?" they asked him. And he said, "I'm fighting because you're down here"....which was a pretty satisfactory answer.
(Shelby Foote, Civil War Historian).

David McCullough and Shelby Foote in Ken Burns', "The Civil War", 1990.

Following an embarrassing defeat of the Federals, by the Confederate army at Wilson's Creek (the "Bull Run" of the west) on August 10, 1861, the war in the Tennessee - Kentucky borderlands had bogged down into a stalemate. Then an obscure Western federal Brigadier General by the name of Ulysses S. Grant came up with a plan to break the deadlock.

By simultaneous use of massive ironclad gunboats and land troops, Grant proposed to advance up the Tennessee River and take the Confederate bastion of Fort Henry. If successful he would them progress in like manner up the Cumberland river and take the Confederate bastion there, Fort Donelson. By the capture of these two forts the Union would gain control of the two vital rivers, and all of Tennessee and Kentucky would be secured for the Union. It was an audacious undertaking.

Fort Henry had been particularly badly sited for a defensive position. It was located on low ground, dominated by heights across the river and subject to flooding when the river rose. Confederate General Lloyd Tilghman once declared of Fort Henry, "The history of military engineering records no parallel in this case!" On February 6th 1862, Fort Henry, after a short, sharp, and virtually bloodless battle fell to Grant. It was the first important Union victory of the war. Fort Donelson on the other hand proved to be a far more formidable challenge. Grant however would be able to bring overwhelming numbers of troops to bear. Within the week he had the Fort completely surrounded by land. As at Fort Henry he then sent the ironclads up river, however this time they took a terrible battering from the Confederate heavy artillery, and all boats had to be withdrawn. Grant next attacked by land but was repulsed. Though Confederate troops were elated at their victories, General John. B. Floyd saw the writing on the wall. Being surrounded, and with Grant daily receiving yet more troops, the situation was ultimately hopeless. On the night of the 15th he held a conference with his leading commanders in order to determine a plan of surrender. All agreed that, though the troops had fought well, surrender was their only real option. Cavalry commander Nathan Bedford Forrest, however was disgusted, and refused to have any part in the surrender. "I did not come here for the purpose of surrendering my command", he thundered, and promptly stormed off into the night. Stunningly he then managed to find an escape route and lead the whole of his cavalry force out of the trap! For the next two and half years Nathan Bedford Forrest would become the cavalry scourge of the Union in the west.

Meanwhile Floyd refused to take responsibility for the surrender. Before the war he had been indicted for various misdemeanours in office as the Secretary of War. It was also a matter of general belief in the North that he had diverted Federal arms and munitions to Southern arsenals on the eve of secession. He was none too eager to become a prisoner of war. Instead he would flee and promote General Gideon Pillow to commander of Fort Donelson! Pillow however had always gone by the catchcry of "Liberty or death!". But when it came to the crunch, he chose liberty. He too would flee and delegate the task of surrender to General Simon Bolivar Buckner. Buckner gallantly accepted the poisoned chalice feeling that he had at least some report with Grant. Years ago he had lent Grant money when had had been destitute following dismissal from his post in California for drunkenness. The magisterial Shelby Foote amusingly described the protocol that followed:

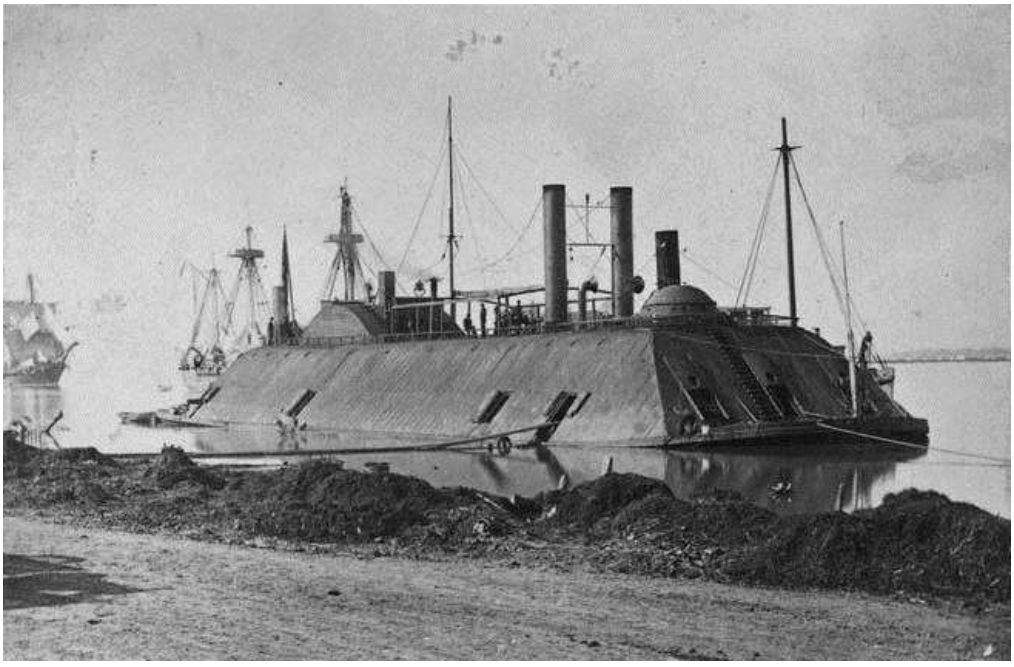
"I turn the command over, Sir", Floyd told Pillow
"I pass it", Pillow told Buckner.
"I assume it," Buckner said, "Give me pen ink and paper and send for a bugler!"

But if Buckner thought his past kindness to Grant would gain some concessions, then he was sadly mistaken.

Confederate troops were disgusted at the thought of surrender, and Buckner's note and white flag of truce had quite some difficulty making it through his own lines. But make it, it did. Grant was woken from sleep by the old veteran General C.F Smith, who breathlessly handed him Buckner's note. Grant read it, then asked Smith what he thought of it. "I think no terms with rebels, by God!", he replied. Grant then penned his famous response and handed it to Smith who read it and pronounced, "By God, it couldn't be better!" Grant would accept no terms, it would be nothing less than "unconditional and immediate surrender!" The phrase, which he would repeat to two further Confederate armies during the course of the war, would become so famous that people said they now knew what his initials stood for, "Unconditional Surrender", Grant! It would become a an American military catchcry, repeated by General Douglas McArthur, to the Imperial Command of Japan, eighty three years later. Grant was not entirely ungenerous in victory. When he met Buckner, he offered him money to help see out his period of captivity. Buckner declined the offer.

Ulysses S. Grant's victories secured Tennessee and Kentucky for the Union. The surrender of the first Confederate army to the Union, marked the first major victory for the North in the American Civil War. It was also the first hint of the emergence of the Union's greatest commander.

When confronted with a dangerous patient barricaded into a Resus cube, and all methods of appeasement have failed, we sadly reach the point where a surrender must be enforced for the ultimate safety of all. Among the measures that must regrettably be taken are activation of our CODE for mechanical restraint. The application of these restraints will require immobilization of all four limbs, but often times violent patients will still persist in dictating their own terms - they must be firmly informed that at this particular point there are no more terms - surrender, must be unconditional and immediate - or we may be forced to move upon their works.



USS ironclad gunboat, "Essex" , Baton Rouge, Louisiana, July 1862

ACUTE BEHAVIOURAL EMERGENCIES - PHYSICAL RESTRAINT

Introduction

The following is intended as *general information* only for the *education* of medical staff and not intended as a legal document nor to overrule or apply to any local / legal / medical practices or guidelines.

Acute behavioural emergencies can arise from:

1. Drug related affects:
    - Including and in particular, **alcohol, sympathomimetic** and **hallucinogenic** agents.
    - Withdrawal syndromes.
2. Psychiatrically disturbed patients.
3. Extreme anti-social/ personality disordered patients.
4. Medical conditions that can lead to an acute delirium.

Note that first three causes often occur in **combination,** and at first assessment it is usually impossible to distinguish the relative contributions of each.

It is the first 3 conditions, rather than a medical condition which *more commonly* lead to *extreme agitation.* Nonetheless medical conditions always need to be considered in the differential diagnosis of these presentations.

When a patient's behaviour is such that there is a significant threat to staff and/ or themselves, then **emergency physical restraint and/ or chemical sedation (or chemical restraint)** may be required.

When a decision is made that emergency physical restraint is necessary, the first priority will be to gather appropriate security (and possibly) police staff to assist. If these resources are not immediately available, then the appropriate Violent/Aggressive person Code should be activated according to hospital guidelines.

See also separate document on:

- **Acute Behavioural Emergencies - Chemical Restraint (in Psychiatry folder).**
- **De-escalation (in Psychiatry folder)**

Legal considerations

By restraining someone physically (or chemically), you are removing the patient from his or her legal rights.

All caution should therefore be taken to consider available treatment options before considering chemical sedation and/ or physical restraint.

Factors relating to duty of care, and the need for psychiatric assessment and treatment need to be taken into consideration.

In a matter of urgency, restrictive interventions may be applied to any person receiving services in a designated mental health service, regardless of legal status, under duty of care. [1]

Legal Definitions [1]

There are a number of **legal terms** commonly employed in mental health policy internationally regarding "**restrictive**" measures:

Restrictive measures include:

Bodily restraint:

- Bodily restraint is defined as a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture.

  While not considered contemporary practice, if cot sides or table tops are used with the intent to restrain, then this does constitute restraint and should be treated and recorded as such.

Physical restraint:

- Physical restraint involves the skilled, hands-on immobilisation or physical restriction of a person.

Mechanical restraint:

- Mechanical restraint involves the application of devices (including belts, harnesses, manacles, sheets and straps) to restrict a person's movement.

Seclusion:

- Seclusion is defined as the sole confinement of a person to a room or any other enclosed space, from which it is not within the control of the person confined to leave.

Any confinement of a person that meets this definition is seclusion, even if the person agrees to, or requests, such confinement.

Clinical Assessment

Assessing these patients is frequently done in conjunction with specialized mental health workers.

It is essential that appropriate security staff and/ or police are near at hand at all times during this assessment, to ensure staff safety.

Less restrictive alternatives to restraint should always be considered initially.

Such methods may include:

1. Verbal de-escalation

2. Close supervision

3. Diversionary activities

4. Behavioural interventions (e.g. enlisting the assistance of trusted friends/ family)

When alternatives strategies have failed - (or are not appropriate, e.g. extreme violence, constituting an immediate danger to staff), activation of the hospital's CODE for responding to violent patients / dangerous patients becomes necessary.

Factors that need to be considered before ordering physical restraint include:

1. The patient:

    - Has become a serious threat to staff (in particular staff feel directly threatened)

    - Has become a serious threat to themselves.

    - Is destroying property.

2. The patient does not appear to be able to make a rational decision.

3. Other less restrictive options have been considered, such as recruiting family members or trusted friends to assist in the patient's management.

4. The patient needs urgent medical assessment, intervention or treatment.

Note that a **registered nurse** may approve the use of physical restraint if it is necessary as a matter of urgency to prevent imminent and serious harm to the person or another

person; and an authorised psychiatrist, a registered medical practitioner or the senior registered nurse on duty is not immediately available to authorise the use

Preparation

Note that in emergency situations, it is not necessary for patients to be recommended by Psychiatry, for physical restraint to be initiated.

If recommendation is necessary, the "paper work" for this may be completed at a later time, when the situation has been stabilized.

When a decision is made that physical restraint is necessary, the first priority will be to gather sufficient and appropriate security staff and/ or police members to physically retrain the patient, as necessary.

Adverse effects

Potential adverse events associated with the use of restrictive interventions include

1. Death:
    - Positional asphyxia
    - Aspiration
    - Chest compression restricting breathing
2. Injury:
    - Soft tissue injury
    - Fractures in the elderly / osteoporotic.
3. High risk of needle stick injury during parenteral chemical restraint
4. Psychological distress:
    - The use of restrictive interventions has the potential to be experienced as a traumatic event and/or trigger previous traumatic experiences.

      Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression.

      Persons of **culturally and linguistically diverse (CALD)** backgrounds may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences such as being a refugee or being a survivor of abuse or torture.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention.

It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions.

Interpreters should be used (telephone or face-face) or cultural advisors, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

The use of a restrictive intervention may also be more traumatic and potentially more dangerous for those who are unable to fully understand what is happening or unable to communicate their questions or concerns due to **sensory impairment**.

Specific interventions, such as the physical restraint of an auditory impaired person's hands, for example may also prevent effective communication. Special care must be taken in these situations to achieve effective communication.

The use of carers who are familiar with the communication needs of the consumer should be considered in these situations.

In cases of prolonged immobilization:

5. Dehydration

6. Incontinence

7. Pressure sores

8. Deep vein thrombosis

Management

1. Call the appropriate **CODE response**, according to local hospital protocols.

   Only those staff specifically trained to "take down" patients, should undertake the process of physical restraint.

2. A minimum of 5 security staff should be available

   - One to secure the patient's head
   - Four to secure the **limbs** (one security staff for each limb)

     Physical restraint techniques which apply direct pressure to the **neck, chest**, **abdomen,** back or pelvic area unsafe and should not be used

Physical restraint techniques that deliberately inflict **pain** must **not** be used. If the patient experiences pain during the use of physical restraint, the technique should be altered to eliminate this.

Personal protective equipment - such as face/ eye masks should be worn by staff in situations where patients spit.

There should be medical and nursing supervision at all times

The coordinating clinician should avoid a "hands on role"; and not become involved in the physical restraint.

The coordinating clinician should supervise the welfare of the patient being restrained in particular with regard to:

- ♥ Airway
- ♥ Breathing
- ♥ Communication (to both security staff and patient)
    - ♥♥ If possible staff should communicate with the patient throughout the procedure, and give continual reassurance that the patient will be safe

Mechanical restraints must be:

- The proper size
- Applied in a manner which maintains correct body alignment
    - ♥ Prone restraint should **not** be used.
- Secured in a way that it can be released quickly if necessary
- Used according to manufacturer specifications
- Applied with the knowledge of the risks associated with the restraint devices.
- Applied in **full**:
    - ♥ Disturbed patients may try to "negotiate" the degree of restraint, however, once the decision has been made that mechanical restraint is necessary then full restraint must be applied.

When the patient has been assessed as being able to be released from restraint, then *all* restraints should be removed.

3. Chemical sedation:

   In most cases, some degree of chemical sedation will then need to follow.

   Note that parenteral chemical sedation of a violent agitated patient is a high risk procedure for needle stick injury. Though not always possible, patients are ideally sedated once they are *fully* restrained.

   See separate document Acute Behavioural Emergencies - Chemical Restraint (in Psychiatry folder).

Nursing observation:

Once mechanical restraints have been applied close one on one nursing by an **appropriately trained** and **experienced** staff member is mandatory.

Observation must be in a **dedicated single patient** cubical.

Cases need to be assessed on an individual basis, however in *general* terms the following are observed and documented:

1. At least **every fifteen minutes**

   - Review of the patient's general condition and position.
     - ♥ Breathing
     - ♥ Alertness and responsiveness
     - ♥ Levels of agitation
   - Response to the restraint and the need to continue bodily restraint
   - Physical and psychological changes

   Very confused, active patients should be reviewed **more frequently.**

2. Hourly:

   - Release restraints (enlisting the help of trained security staff):
     - ♥ Check: skin integrity, sensation, circulation and joint mobility
   - Sufficient hydration

- Correct re-application of restraint

3. Two Hourly:

   General care including:

   - Hygiene
   - Exercise
   - Re-positioning
   - Toileting

Meeting specific individual needs (based on culture, language, age, disability, religion, gender, sexuality, trauma history, vulnerability) is also important .

Discontinuing restraint:

There is no completely safe time limit for the duration of any physical restraint technique.

As a general principle, physical restraint must be ceased as soon as the situation is deemed to be safe.

The Medical Officer supervising the patient's care is ultimately responsible for the decision to discontinue the restraint.

Documentation:

All instances of patient restraint should be appropriately documented.

Documentation should include:

- A description of the person's condition at the commencement of the intervention.
- The rationale for the use of restrictive interventions.
- Details arising from the nursing observations or review.
- Any medication or treatment provided and the response to treatment.
- The outcome of the initial and four-hourly medical examinations.
- Details of second opinions and/or case conference reviews.
- The nursing care plan.

- Confirmation relevant persons have been notified of the use of the restrictive intervention

Case conference and second opinion:

Where the restrictive intervention is used for extended periods of time or on a recurrent basis, it is good clinical practice to undertake a case conference.

Patients who repeatedly behave in a manner that threatens themselves or others and whose symptoms fail to respond to a full range of clinical interventions pose particular clinical challenges that require careful consideration and management.

The reasons for the repeated behaviour should be explored and understood with the patient.

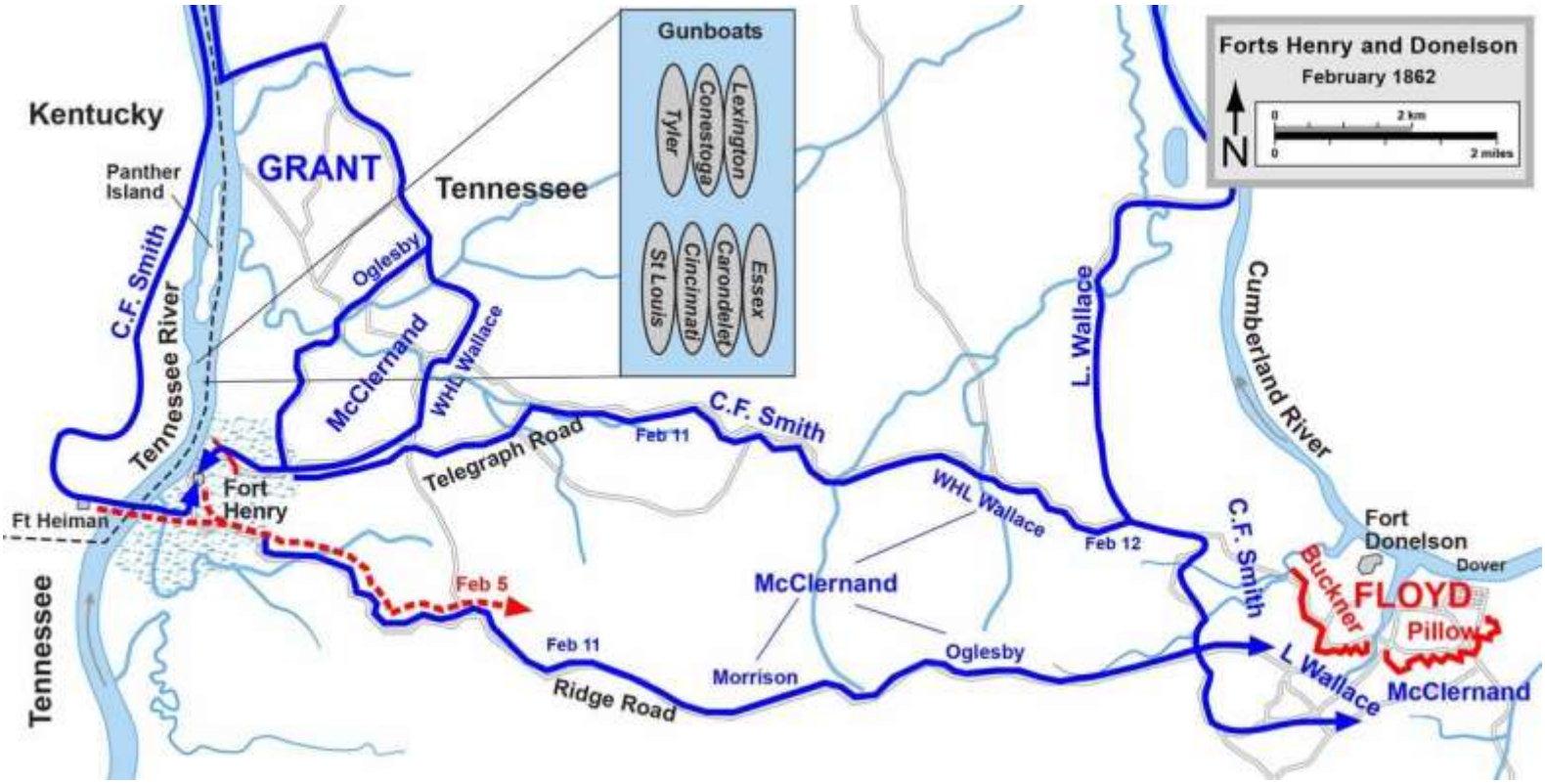
A thorough review of the person's history, treatments attempted and their duration, medication administered and responses, as well as the impact of contextual factors (e.g. organisational factors, the environment and team functioning) should be undertaken by the treating team (inclusive of consumer consultant involvement) and may be the subject of a **case conference**.

This should include the consumer and carer directly involved where possible.

It is also good clinical practice to obtain a **second opinion** to review the consumer's management with prolonged or recurrent use of a restrictive intervention. This should be a second opinion **external** to the treating team.

A detailed care plan should be developed that:

- Describes the behaviour in question.
- Identifies the precipitating and exacerbating factors.
- Outlines strategies aimed at reducing the behaviour and the need for a restrictive intervention.
- Outlines a graded series of responses.



The Battles of Fort Henry & Fort Donelson, February 1862

References

1. Chief Psychiatrist's guideline: Restrictive interventions in designated mental health services. Department of Health, Victoria, 2014

   - www.health.vic.gov.au/mentalhealth/cpg/

2. eTG - November 2017.

   - Acute Behavioural Emergencies, Psychiatric Therapeutic Guidelines, 7th ed 2013.

Dr J.Hayes
2 May 2018